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**MEMORANDUM**

**TO:** Amanda Eby, Christina Goe  
**FROM:** Nancy McCall, Kristin Geonnotti  
**SUBJECT:** Utilization Measures Worksheet

**DATE:** 3/4/2015

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As described in Montana's draft guidance to payers, the methods for calculating and reporting the two required utilization measures are as follows:

**Emergency Room Visits (ER Visits per 1,000\*)**

*ER Visits per 1,000 is the average number of emergency room facility visits provided under medical coverage, per 1,000 members with medical coverage per year. The number of visits is based on the count of unique patient and service date combinations (ER Visits/(Member Months/1000))\*12. If attributed population data is available, this calculated rate will be applied for comparison to the population consisting of the entire payor's fully insured book of business, and to the population consisting of members with 7 or more months of contiguous attribution to a PCMH within a single calendar year for the reporting period.*

**Hospitalization Rates (Admits per 1,000\*)**

*Admits per 1,000 is the average number of acute admissions per 1,000 members with medical coverage per year (Admits/(Members Months/1000))\*12. If attributed population data is available, this calculated rate will be applied for comparison to the population consisting of the entire payor's fully insured book of business, and to the population consisting of members with 7 or more months of contiguous attribution to a PCMH within a single calendar year for the reporting period.*

To ensure comparability across payers, stakeholders may wish to consider several issues that are sometimes handled differently when calculating claims-based utilization measures. It will be important to balance flexibility and ease of reporting for payers with standardized measure definitions to ensure that these measures can be used to adequately and accurately assess performance for the Montana PCMH initiative. For the March 31, 2015 reporting requirement, there may be insufficient time for payers to modify their claims extraction and aggregation processes; however, this worksheet can then serve as documentation of similarities or differences in how utilization measures were calculated for this reporting period and serve as a tool for discussion for future reports.

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We have briefly described several common issues below, with questions to facilitate a discussion among stakeholders and payers for each issue. We also recognize that there may be other issues not listed here, and are interested in learning more about these from participating payers to inform future the reporting and data submission processes for the Montana PCMH initiative.

## **1. HOSPITAL ADMISSIONS**

### **A. Types of Facilities**

It will be important that all payers submit data for similar hospitalizations, coming to a consensus on (a) which types of hospitalizations are included (b) how these hospitalizations are defined. The table below describes the most common inpatient facility types and the ways in which they are often defined using CMS Certification Numbers.

Type of Facility	CMS Certification Numbers
Short-term (general and specialty) hospitals	0001-0879
Critical access hospitals	1300-1399
Rehabilitation hospitals	3025-3099
Rehabilitation distinct part unit	R or T in third digit
Long-term care hospitals	2000-2299
Swing-bed hospital designation	U, W, Y, Z in third digit
Psychiatric hospitals	4000-4499
Psychiatric distinct part unit	M or S in third digit

#### Questions for stakeholders:

- 1. Which hospital types do you currently include in your calculations of the utilization measures?*
- 2. How are these hospitals defined?*
- 3. Are all reported hospitalizations only occurring in Montana or are you reporting utilization for all Montana residents that you cover regardless of location of admissions?*
- 4. Are there other types of facilities that should be included?*
- 5. Are there any types of facilities that should be excluded?*

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## **B. Transfers between acute care facilities or units within a hospital**

In creating hospitalization rates, health services researchers often combine multiple claims that represent pieces of stays or transfers between acute care hospitals, or separately administered units of a single hospital, into a single record representing one admission. This is done if payers make separate payments for care provided in different facilities or units of a facility within one continuous episode of care. Combining the components of an episode reduces the number of admissions and readmissions that would otherwise be calculated. This is often done to avoid having subsequent admissions appear to be readmissions when they could more accurately be characterized as continuations of the same episode of care.

### Questions for stakeholders:

- 1. When counting hospitalizations, how do you report the components of care during a continuous episode?*
- 2. What components of care do you feel should be rolled into a single episode?*

## **C. Observation Stays**

Hospitals can provide services on either an inpatient or outpatient basis; observation status is often used as an outpatient designation while clinical determination of whether a patient needs to be admitted as an inpatient is being made. Observation policies can vary by payer; for instance, Medicare recently enacted a two-midnight rule to clarify that only a patient whom the physician believes will need to spend two nights in the hospital will be considered an inpatient. While the guidelines surrounding observation stays may vary by payer, it will be important to build consensus as to how these types of short-term hospital episodes are treated using claims data and how this will ultimately affect the calculations of the two utilization measures. Options could include classifying observation stays as an:

- **Observation stay** – count these stays as a separate category and exclude from ED visits and inpatient hospitalization measures.
- **ED visit** – count observation stays under the category of ED visits, rather than being classified separately.
- **Inpatient hospitalization** – count as a hospitalization.
- **Hybrid approach** – as discussed below, ED visits are sometimes rolled into the inpatient admission if it is a continuous episode of care and reported as an ED visit when there is no subsequent hospitalization. One could consider a similar approach for observation bed stays.

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Questions for stakeholders:

1. *Do you currently have guidance surrounding the billing or classification of observation stays?*
  - a. *How do you define when an inpatient admission starts?*
  - b. *In observation cases, do you have anything similar to Medicare's two-midnight rule or a minimum amount of time that a patient must be "in a certified inpatient bed" before considering an admission?*
2. *How would you recommend classifying observation stays in calculations of the utilization measures?*
3. *Are there other related billing practices to consider when calculating the utilization measures?*
  - a. *For example, in hospitals with swing beds, how are services differentiated as acute care or SNF (and classified as such when calculating these utilization measures).*
  - b. *Other issues?*

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## **2. EMERGENCY DEPARTMENT (ED) VISITS**

### **A. Classifying ED Visits**

As you are aware, some ED visits lead to an inpatient admission, while other patients are discharged from the ED. In ensuring a consistent utilization measure for ED visits, the way in which these claims are handled is important. Some payers may choose to count all ED visits separately, regardless of status when the patient leaves the ED, while others may separate ED visit type based on discharge status—counting those who are discharged as ED visits, and rolling those resulting in an inpatient admission into part of the overall inpatient hospitalization.

#### Questions for stakeholders:

1. *Do you count all ED visits regardless of disposition in your report of ED visits?*
  - a. *Or do you exclude from the count of ED visits those that lead to a hospitalization?*
  - b. *Disposition to any other institutional facility?*
2. *If ED visits are counted as part of the admission, are any ED visits ever excluded from your measure of inpatient admissions?*

### **B. ED Visits on the Same Day**

In the event of two ED visits on the same day, many health services researchers collapse the two ED visits into one ED visit. This is to avoid over-counting ED visits, as multiple visits on the same day could be considered the same episode of care. Two visits on subsequent days are then considered two separate ED visits.

#### Questions for stakeholders:

1. *Do you count ED visits on the same day as separate visits, where a patient can only have 1 ED visit per day, or do you count each individual event?*
2. *Which method would you recommend for calculating these utilization measures?*

## **3. OTHER ISSUES IN COUNTING HOSPITALIZATIONS OR ED VISITS**

Are there other issues the stakeholder group would like to consider to ensure standard reporting of the two utilization measures?